

## Sublingual Testing in the Diagnosis of Food Allergy

TO THE EDITOR: The accurate diagnosis of food allergy has always been difficult, even though there is little problem in identifying a pronounced acute allergic or anaphylactic response to a specific food. The patient and his family usually recognize severe allergy before the physician is consulted in such cases, and the food is avoided. Difficulties arise when symptoms are mild or chronic or when they appear several hours or more following food ingestion. In recent years a number of physicians have used sublingual drop or extract injection techniques to assist in sorting out the less obvious cases of food allergy. Not until recently has either of these techniques been subjected to objective double-blind evaluation. Unfortunately, to date both have been found to be wanting since results were not reproducible when tests were repeated in a different order at a later date.

The writer participated in a study of sublingual tests conducted by the Food Allergy Committee of the American College of Allergists, and thereafter made additional tests by double-blind protocol. The results obtained on the 12 allergic patients studied supported the committee findings, that is, the tests had no reliable reproducibility under double-blind conditions. Several observations of interest were made. Eleven of the 12 reported symptoms following one or both challenges with one or more of the five food extracts or the placebo. Six patients had symptoms following both challenges with an extract, but when the code was broken it was found that symptoms were different after the second challenge in five of the six. The patient whose symptoms were reproduced had similar symptoms following the placebo. Eight of 12 patients reported symptoms following challenge with placebo, four on both occasions. The four had different symptoms following each placebo challenge. Many symptoms previously experienced by a patient reappeared following administration of a food extract or the placebo, but seldom did the symptoms correlate with foods suspected by history.

It is hard to escape the impression left by the over-all study that patient anticipation at times may be a dominant factor in inducing either symptoms or observable responses including rhinorrhea, lacrimation, hoarseness, pruritus, wheezing and changes in the pulse rate.

Indeed, one is led to the speculation that the

"apparent value" of such tests as reported by a few physicians experienced in their use may result from the test situation providing an attractive means for the patient to express his conscious or subconscious belief that the food being tested caused untoward reactions in the past. It may be unwise to make a blanket denial that this kind of information could help in the management of selected patients. Nevertheless, since physicians are obliged to provide maximal value for the fees the patients pay, this procedure must be considered experimental at present.

DOUGLAS C. HEINER, MD  
Los Angeles

### REFERENCES

Report of the Food Allergy Committee Study on the Sublingual Method of Provocative Testing for Food Allergy (Committee of the American College of Allergists, JC Breneman, Chairman). *Ann Allergy* 31:382-385, Aug 1973

Report of the Committee on Injection Provocation Food Testing (An ad hoc committee of the American College of Allergists, I Caplin, Chairman). *Ann Allergy* 31:375-381, Aug 1973

Morris DL: Use of sublingual antigen in diagnosis and treatment of food allergy. *Ann Allergy* 27:289-294, 1969

## Disc Lesion Management

TO THE EDITOR: In regard to the article on disc lesion management [Blau L, Kent L: Conservative and Surgical Aspects of Disc Lesion Management—Follow-Up Review of 2,214 Cases. *West J Med* 120:353-357, May 1974] the authors quote their poor results in correlating electromyographic findings with objective nerve root compression. In their discussion of the EMG, they quote from Dr. E. W. Johnson's article, indicating it was used for the format of their electromyographical studies. However, when they describe their procedure, they discuss the resting state which is step one; the minimal contraction which is step three; and the maximum contraction which is step four; but they omitted the insertional activity which is step two in Dr. Johnson's paper.

In reviewing several articles which have been written by Dr. Johnson, he indicates that the most sensitive part of the examination for finding abnormal muscular irritability "positive sharp waves and fibrillation occurs during step two, the insertional activity." If step two of the electromyographical examination was omitted, this could easily account for your rather disappointing results in correlating positive findings of EMG with objective root compression.

J. H. KENNEDY, MD  
Associate Medical Director  
Physical Medicine and Rehabilitation  
Rehabilitation Institute of Oregon  
Portland